DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 12/06/14

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445295	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTON MANOR	3641 MEMORIAL BLVD KINGSPORT, TN 37664

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K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and testing, it was determined that the facility failed to have exits readily accessible. The findings include: Observation and testing on October 21, 2014 at 2:20 p.m. revealed that the service hall delayed egress exit door leading out to laundry did not alarm or release after force was applied to the door for more than 3 seconds. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on October 21, 2014. NFPA 101 7.2.1.6.1	K 038	K038 Exit access (1) The cited magnet release was repaired on 10/22/14 by the manufacturer's local representative. (2) Every magnetic lock in the facility was checked and one, the main entrance, was repaired in addition to the cited lock. This repair was also performed by the manufacturer's authorized representative. All residents could have been affected by the exit's inaccessibility. (3) Magnet checks are on the regular monthly preventive maintenance schedule. Maintenance PM logs will be reviewed monthly by the administrator. (4) Results of the PM mag lock checks will be reported quarterly to the QA&A Committee for 2 quarters., November, 2014 and February, 2015. All corrections, including the first QA&A review, will be completed by 12/6/14	10/22/14 10/22/14 10/22/14 11/20/14 12/6/14
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to maintain the automatic sprinkler	K 062		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Edward E. Smith | TITLE: Administrator | (X6) DATE: 11/14/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 062	Continued From page 1 system. The findings include: Observation on October 21, 2014 between 11:20 a.m. and 3:20 p.m. revealed the following: 1. Dining room has to 2 light fixtures by the projector screen that are hung from the sprinkler lines. 2. Dietary has 3 of 14 sprinkler heads that are loaded with a lent and debris. 3. In the corridor by room 416 - 500 have 9 of 13 sprinklers that have paint overspray on the sprinkler head. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on October 21, 2014. NFPA 13 6-1.1.5*, NFPA 25 2-2.1.1*	K 062	K062 Sprinkler system maintenance 1- Corrective actions (1) Hanging lights were removed from sprinkler piping by the maintenance assistant on 10/22/14. (2) Dirty sprinkler heads were cleaned by the maintenance assistant on 10/23/14. (3) Paint spray was cleaned off 400-500 corridor sprinkler heads by the Director of Maintenance on 10/23/14. 2- The facility was inspected for the presence of dirty heads and/or system obstructions on 10/23/14 by the maintenance team. All residents had the potential to be affected by the issues cited. 3- Sprinkler system checks are on the regular monthly preventive maintenance schedule. Also, a sprinkler consulting company checks the entire system every 6 months. Maintenance PM logs and vendor reports will be reviewed monthly and/or q 6mos by the administrator.	10/22/14 10/23/14 10/23/14 10/23/14 10/22/14
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.	K 066	4- Results of the checks will be reported quarterly to the QA&A Committee for 2 quarters., November, 2014 and February, 2015, and vendor reports as received going forward. All corrections, including the first QA&A review, will be completed by 12/6/14	12/06/14 12/6/14

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K 066	Continued From page 2 (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to have metal containers with self-closing lids in all smoking areas. The findings include: Observation on October 21, 2014 at 2:42 p.m. revealed 2 of 3 smoking areas are not provided with metal containers with self-closing lids into which ashtrays can be emptied into. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on October 21, 2014.	K 066	K066 Adherence to adopted smoking regulations 1- Self-closing metal containers were placed in every smoking area by the maintenance staff on 10/22/14. 2- The entire facility was inspected by the maintenance staff on 10/22/14 to see if the appropriate containers were present. All residents had the potential to be affected by the issues cited. 3- Smoking areas are inspected monthly as part of our preventive maintenance. The administrator reviews results with the Director of Maintenance monthly. 4- Results will be reported quarterly to the QA&A Committee for 2 quarters., November, 2014 and February, 2015. All corrections, including the first QA&A review, will be completed by 12/6/14.	10/22/14 10/22/14 10/22/14 12/06/14 12/6/14
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the all fire rated assemblies. The findings include:	K 130		

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K 130	Continued From page 3 Observation and interview with the maintenance director on October 21, 2014 at 2:10 p.m. and 2:15 p.m. revealed the 1 hour fire rated ceiling assembly has 4 unsealed penetrations. 1. 2 large openings have been cut out for previous repairs approximately 4 months ago and have not been sealed appropriately. 2. 1 penetration by the sprinkler pipe going through the ceiling by the kitchen hood. 3. 1 unsealed penetration by the walk in cooler. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on October 21, 2014. NFPA 101 8.2.3.2.4.1*	K 130	K130 Other – unsealed penetrations 1- All 4 penetrations were patched by the Director of Maintenance on 10/23/14. 2- The entire facility was inspected by the maintenance staff on 10/22/14 to see if other penetrations were present and we found no others. All residents had the potential to be affected by the issue cited. 3- Maintenance reviews the facility for new penetrations as part of its monthly preventive maintenance. The administrator reviews results with the Director of Maintenance monthly. 4- Results will be reported quarterly to the QA&A Committee for 2 quarters., November, 2014 and February, 2015. All corrections, including the first QA&A review, will be completed by 12/6/14.	10/23/14 10/22/14 10/23/14 12/06/14
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and testing, it was determined that the facility failed to maintain electrical wiring and equipment in accordance with the National Electric Code. The findings include: Observation and testing on October 21, 2014 between 2:25 p.m. and 3:05 p.m. revealed the following: 1. Electrical outlet in the service hall that leads to laundry shows an "open ground". 2. Electrical outlet in the corridor by physical therapy shows a "hot and neutral reversed".	K 147		12/6/14

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K 147	Continued From page 4 3. The 2 small dining rooms off of the main memory care dining room shows an "open ground" 4. Electrical out in the corridor by room 101 shows an "open ground" 5. Nurse call outlet between the beds is detached and loose in the wall. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on October 21, 2014. NFPA 70 110-13(a), 250-2(a), NFPA 101 19.5.1, 9.1.2	K 147	K147- maintain electrical wiring & equipment per NEC 9.1.2 1- All cited areas were corrected by the Director of Maintenance on 10/23/14. 2- The entire facility was inspected by the maintenance staff on 10/22/14 to see if other electrical issues were present and we found no others. All residents had the potential to be affected by the issues cited. 3- Maintenance reviews the facility for new electrical issues as part of its monthly preventive maintenance. The administrator reviews results with the Director of Maintenance monthly. 4- Results will be reported quarterly to the QA&A Committee for 2 quarters., November, 2014 and February, 2015. All corrections, including the first QA&A review, will be completed by 12/6/14.	10/23/14 10/22/14 10/23/14 12/06/14 12/6/14